STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085020	A. BUILDING _____ B. WING _____	C 08/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE REHABILITATION & HEALTH CENTER	3034 SOUTH DUPONT HIGHWAY SMYRNA, DE 19977

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F 000	INITIAL COMMENTS Revised report with corrected resident identifier for F842. An unannounced complaint investigation survey and the extended survey was conducted at this facility from August 1, 2018 through August 8, 2018. The facility census on the first day of the survey was 141. The survey sample totaled 16. Abbreviations/definitions used in this report are as follows: NHA-Nursing Home Administrator; DON-Director of Nursing; ADON-Assistant Director of Nursing; BOM-Business Office Manager; MD-Medical Doctor; CNA-Certified Nurse's Aide; LPN-Licensed Practical Nurse; RN-Registered Nurse; ROM-Regional Operations Manager; RRT - Registered Respiratory Therapist, certified to provide care for residents with breathing problems; RSW-Regional Social Worker; UM-Unit Manager; Abnormal Involuntary Movement Scale (AIMS) - An assessment to record presence of tardive dyskenisia (TD) in those individuals taking medications, such as antipsychotic medication; Accidental extubation - unplanned removal of tracheostomy tube; Activities of daily living (ADLs) - tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; Acute renal failure - sudden and often temporary loss of kidney function;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/31/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Addison's Disease (common name for primary adrenal insufficiency) - condition where adrenal glands (located above kidneys) do not function requiring life-long treatment with steroid hormones; Adrenal glands-glands that produce a variety of hormones; ACTH - adrenocorticotropic (or adrenocorticotrophic) hormone produced by the pituitary; . Adrenal Crisis - medical emergency from adrenal gland malfunction and not receiving steroid hormones; Antipsychotic medication- class of medications used to manage mental and emotional conditions; Agitation - -feeling restless, not calm; Albuterol - medication to make it easier to breathe; Ambu bag - a hand-held device to provide air/oxygen into the lungs when someone is not breathing, or not breathing adequately; Ativan - medication to treat anxiety; Atrial fibrillation - irregular heartbeat; Blood pressure - the pressure of the blood in the circulatory system, often measured for diagnosis since it is closely related to the force and rate of the heartbeat and the diameter and elasticity of the arterial walls; BKA-below the amputee (removal of a potion of the leg); Contact precaution - used to prevent the spread of diseases that can be spread through contact; . Decannulation - removal of the tracheal breathing tube; Dehydration - condition when the loss of body fluids, mostly water, is greater the amount taken in; Diabetes mellitus - commonly referred to as	F 000		

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F 000	Continued From page 2 "diabetes", a chronic disease associated with high levels of the sugar/glucose in the blood; Dyspnea - shortness of breath; Edema - is the abnormal accumulation of fluid in certain tissues within the body; e.g.-for example; eMAR- electronic Medication Administration Record, documentation of medications which were administered; EMS - Emergency Medical Services, ambulance staff; Endotracheal tube - flexible breathing tube; ER - Emergency Room; etc.-and so forth; Fats (in blood) - Cholesterol is a waxy fat-like substance in the blood; Finger Stick Blood Sugar (FSBS) - drop of blood from a finger is used to measure blood sugar. Normal fasting blood sugar level is 70 to 100 mg/dl; Gastroesophageal reflux disease (GERD) - a digestive condition; Glucocorticoids - any group of corticosteroids medication (e.g. hydrocortisone) which are involved in the metabolism of carbohydrates, proteins, and fats and have anti-inflammatory activity. Gout - a kind of arthritis caused by a buildup of uric acid crystals in the joints; Hallucinations - something that seems real but does not really exist, may be visual (seen) or audio (heard); Hyperlipidemia - an abnormally high concentration of fats or lipids in the blood; Hypoxia/Hypoxic - inadequate amount of oxygen in the blood; Lipids - is fat in the blood; L (liters) - amount of oxygen measured in LPM (liters per minute);	F 000		

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F 000	Continued From page 3 MDS Assessment - A clinical assessment documentation; Mental retardation - a developmental disability that first appears in children under the age of 18. It is defined as an intellectual functioning level (as measured by standard tests for intelligence quotient) that is well below average and significant limitations in daily living skills; . meq. (milliequivalent) - represents one-thousandth of an equivalent of a compound or chemical substance;. mg. (milligram) - metric unit of weight measurement, 1 mg equals 0.0035 ounce; mg/dl (milligrams per deciliter) - unit of measure of concentration of a substance in a specific amount of liquid; mcg-microgram; NC (Nasal Cannula) - device used to deliver oxygen into the nose; Nebulizer - machine that turns liquid medication into a mist that can be inhaled directly into lungs; Neurological assessment - physical examination of the nervous system; NN-nurses note; Obstructed airway - blockage that prevents air from getting into the lungs; Obtuned -mentally dull, less than full alertness; Omni-cell - a machine that dispensed medications to authorized staff; O2 - oxygen; Oxygen saturation (sat.) - level of oxygen in the blood; P (pulse) - heart rate in beats per minute; Patency - the degree of openness of a tube, relative absence of blockage; % - percent; P and (&) P- policy and procedures; Paranoia-fearful, intense anxiety and suspicious; Personal Protective Equipment (PPE) -refers to	F 000		

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F 000	Continued From page 4	F 000		

protective clothing, helmets, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection;
Pituitary - A pea-sized body attached to the base of the brain, the pituitary is important in controlling growth and development and the functioning;
Pneumonia - lung infection;
Post-after;
PRN - as needed;
Progress Note - clinical documentation of care and services provided to the resident by facility staff;
Psychiatrist - doctor specializing in mental disorders;
Psychosis-loss of contact with reality;
Psychoactive medication - drug used to change brain function to change mood, perception or consciousness;
Pulse - Heart rate per minute;
Pulse oximetry [ox] - measures blood oxygen saturation levels - desired range 94% to 100%;
Respiration rate - number of breaths per minute;
Respiratory failure - condition when not enough oxygen passes from the lungs into blood;
Sedation - state of calm or sleep, can be caused by medication;
Sepsis - serious condition resulting from the presence of harmful microorganisms in the blood or other tissues and the body ' s response to their presence, potentially leading to the malfunctioning of various organs, shock, and death;
Seroquel-antipsychotic medication;
Shiley trach - brand of tracheostomy tube;
Stoma - artificial opening made into a hollow organ from the outside of the body;
Suctioning - removal of secretions from the airway and lungs that cannot be remove by coughing;

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F 000	Continued From page 5 Subcutaneously-under the skin; Super-San-Cloth Germicidal Disposal Wipes - disinfectant wipes; Tardive Dyskenisia (TD) - side effect of antipsychotic medication; Temperature - the degree or intensity of heat present in a substance or object; Trach (tracheostomy) tube - a breathing tube that is placed through the neck into the windpipe to assist with breathing. It consists of three parts: outer cannula with flange (neck plate), inner cannula, and an obturator which is used only for insertion and is immediately removed. The inner cannula fits inside the outer cannula and is changed/replaced by the nurse; Trach care - nurse cleans around stoma, replaces gauze around the stoma, changes the inner cannula, changes trach ties if soiled; Trach collar or ties - medical device wrapped around the neck to secure a trach tube in its position. Trach plug or cap - covers the opening of the trach tube (often a red cap) and blocks air from entering the tube and forces the patient to breathe in and out through their nose and mouth; Trachea - breathing tube from the neck to the lungs; Uric acid - is produced during the breakdown of specific substance, which are found in certain foods and are also formed by the human body. Urinary tract infection - infection of any part of the urinary system; XLT-extra large.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice	F 585		9/18/18

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F 585	Continued From page 6 grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of	F 585		

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F 585	Continued From page 7 independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in	F 585		

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F 585	Continued From page 8 accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, family interview, and review of other facility documentation as indicated, it was determined that the facility failed to ensure that complaints received by the facility included prompt efforts to resolve problems for one (R5) out of 16 residents sampled. In addition, the facility failed to ensure a written decision was issued to the complainant. Findings include: Review of the facility's Grievance and Concerns/Complaint Policy, revised and adopted on 11/28/16 indicated: - Any resident, his or her representative, family member, or advocate may file a grievance or complaint in writing, verbally, or anonymously concerning his or her treatment, medical care, behavior of other residents, staff members, theft of property, etc. without fear of threat or reprisal in any form. - The resident, resident or representative or person filling out the grievance and/or complaint on behalf of the resident will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. Such report will be made verbally by the Social	F 585	A. R5 has been discharged from the facility. A copy of the resolution summary was mailed to the complainant on 8/27/18. B. A copy of the resolution summary was mailed to the complainant on 8/27/18. The grievance log audit has been completed for the past 30 days by the Director of Social Services. All grievances identified as incomplete or where the complainant was not notified has been corrected. C. The social services department has been re-educated on the grievance policy and procedures, grievance form, completion of the grievance form and identified recipients of the resolution summary. D. Grievance compliance audits will be completed by the Social Services Director or designee weekly X4 until 100% compliance is achieved, monthly X3 until 100% compliance is achieved with results reported to the QAPI Committee monthly X3.	

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F 585	Continued From page 9 Services Director/Grievance Official or his/her designee, promptly within filing of the grievance or complaint with the facility. 1a. Review of the facility's Grievance Log revealed: 7/11/18 - Resident/Family Grievance Report documented that family members of R5, FM1 and FM2, voiced multiple complaints to E40 (Regional Social Worker). The report documented that the issues were confirmed and resolved. The section for "Resolution" was blank, thus, the facility failed to have evidence that the complainants were informed of the findings of the investigation and the actions that was taken to correct any identified problems. Despite the lack of follow-up with FM1 and FM2, the form contained the signatures of E1 (NHA) and E39, the facility's Grievance Officer (GO), with a date of 7/31/18. 7/30/18 - Grievance/Concern Form Written Decision/Resolution, dated 7/30/18, was addressed to R5's designated responsible party, FM3 and not addressed to FM1 and FM2 who were the complainants on 7/11/18. This documentation included the signatures of E1 and E39. 8/6/18 at 10:07 AM - A telephone interview with FM1 revealed that he had made numerous complaints and FM1 verbalized that the facility has not followed up with him regarding the findings of the facility's investigation and actions taken to correct the problems. In addition, FM1 reported that he has not received a written grievance decision. 8/6/18 at approximately 6:00 PM - An interview	F 585		

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F 585	Continued From page 10 with E39 confirmed that the above 7/30/18 correspondence was sent to FM3 on 8/1/18 or 8/2/18 and not to the complainants, FM1 and FM2. No reason was given as to the lack of follow-up with FM1 and FM2 and no reason as to why the correspondence was sent to FM3 rather than FM1 and FM2. 1b. Review of Grievance Log Revealed: 7/23/18 - Resident/Family Grievance Report documented a new complaint by FM1. The report documented that the issues were confirmed and resolved. The section for "Resolution" documented that the facility contacted FM3 rather than FM1 with the follow-up to the complainant and that FM3 was satisfied with the actions taken by the facility. There was lack of evidence that the facility had informed FM1 of the findings of the investigation and the actions that was taken to correct any identified problems. The form contained the signatures of E1 (NHA) and E39, with a date of 7/31/18. 7/30/18 - Grievance/Concern Form Written Decision/Resolution, dated 7/30/18 was addressed to R5's designated responsible party, FM3 and not addressed to FM1 who voiced the grievances on 7/23/18. This documentation included the signatures of E1 and E39. 8/6/18 at 10:07 AM - A telephone interview with FM1 revealed that he had made numerous complaints and FM1 verbalized that the facility has not followed up with him regarding the findings of the facility's investigation and actions taken to correct the problems. In addition, FM1 reported that he has not received a written grievance decision.	F 585		

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F 585	Continued From page 11 8/6/18 at approximately 6:00 PM - An interview with E39 confirmed that the above 7/30/18 correspondence was sent to FM3 on 8/1/18 or 8/2/18 and not to the complainant, FM1. 8/8/18 at approximately 3:15 PM - Above findings were reviewed with E1 (NHA) and E2 (DON).	F 585		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656		9/18/18

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F 656	Continued From page 12 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to develop a comprehensive care plan in the area of respiratory impairment for 1 (R14) out of 3 sampled residents with a tracheostomy tube. Findings include: Cross Refer F695, Example 1a. Review of R14's clinical record revealed: 6/13/18 - Admission to facility with a tracheostomy tube for rehabilitation. 6/18/18 (7:31 PM) - Progress note documented resident performed own trach care and demonstrated understanding of technique. 8/3//18 - Review of the resident's care plan developed on admission of 6/13/18 found no evidence of a care plan addressing R14's respiratory status or tracheostomy tube. 8/6/18 (9:00 AM) - Review of the care plan found	F 656	A. R14□s care plan has been updated to reflect the respiratory self-care status. R14 had a comprehensive care plan in place at time of survey. No other residents care plans were identified as being deficient. B. An audit of all residents with tracheostomies has been completed with no further corrective action needed. C. All nursing Unit Managers and Supervisors will be in-serviced by the Staff Educator RN or designee on developing a comprehensive care plan as well as updating care plans to reflect current respiratory status. D. Care Plan Audits related to updating tracheostomy care will be conducted by the DON or designee weekly X4 until 100% compliance is achieved, monthly X3	

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F 656	Continued From page 13 a problem for respiratory impairment added and dated 8/6/18 in response to surveyors investigating the presence of emergency equipment at the bedside on 8/3/18. However, the care plan did not address the resident's independent performance of trach care. This findings was reviewed with E1 (NHA) and E2 (DON) during the exit conference on 8/8/18 beginning at 3:15 PM.	F 656	until 100% compliance is achieved. Results will be reported to the QAPI committee monthly X3.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657		9/18/18

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F 657	Continued From page 14 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other facility documentation it was determined that the facility failed to revise the care plan for 1 (R6) out of 16 sampled residents to reflect current fall prevention needs. Findings include: : Cross refer F689, Example #1. The following was reviewed in R6's record: 4/8/18 - R6 admitted to the facility for rehabilitation after being hospitalized. 4/9/18 - Care plan initiated for at risk for falls due to decreased mobility, but did not include "may not go outside unattended". 5/4/18 at 10:15 AM - E31 (Business Office Manager) witness statement: I was on the phone in my office when I noticed R6 falling out of his wheelchair. He was self-propelling and his left front wheel went off the curb, causing his wheelchair to fall to the left. R6 fell on his left side and hit his head on the left side. His left arm was behind his back when he hit the ground. I immediately interrupted morning meeting to have a nurse respond. I called 911 to have an ambulance respond." 5/10/18 - Revisions to Care plan for at risk for falls: Interventions added to send to Emergency Department for evaluation and therapy to screen upon return, but did not include "may not go outside unattended".	F 657	A. R6 has been discharged from the facility and no corrective action can be taken. B. An audit of all residents at risk for falls with a verbalized request to go out of doors unattended will be screened by the therapy department for safety. The care plan has been revised to reflect the resident□s out of door unsupervised current status. C. All nursing Unit Managers and Supervisors will be in-serviced by the Staff Educator RN or designee on revision of care plans timely to reflect current out of doors unsupervised status. D. Care Plan Audits related to timely revisions of out of door status will be conducted by the DON or designee weekly X4 until 100% compliance is achieved, monthly X3 until 100% compliance is achieved. Results will be reported to the QAPI committee monthly X3.	

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F 657	Continued From page 15 8/6/18 at 11:00 AM - Interview: E34 (Receptionist) stated that on 5/4/18 when R6 fell, she did not realize R6 had gone outside unattended in the wheelchair. Now the front door is locked and E34 has a button at the front desk to unlock the front door. Also, E34 now posts the names and photos of all the residents that have been cleared to go outside unattended. 8/6/18 at 11:40 AM - Interview: E33 (Physical Therapist) stated that for residents to be able to go outside unattended therapists must evaluate and clear them to be safe. If a resident was cleared, they will be put on a list of residents who may go outside unattended. E33 stated R6 was not safe to go outside unattended and was not on the list to go outside unattended. 8/8/18 at approximately 3:15 PM - Above findings were reviewed with E1 (NHA) and E2 (DON) during Exit Conference.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and review of medical references, it was determined that for 1 (R5) out of 3 sampled residents, the facility failed to provide services that met professional standards of quality. Findings include: The facility's Nursing Policy titled Falls	F 658	A. R5 has been discharged from the facility and no corrective action can be taken. B. All residents having falls have the potential to be affected by this deficient practice.	9/18/18

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F 658	Continued From page 16 Management, with the revision date of 3/15/16, indicated that patients experiencing a fall will receive appropriate care and investigation of the causes. Mosby's nursing book entitled Priorities in Critical Care Nursing 5th edition, dated 2008, stated, "...Trauma...Blunt trauma is seen most often with...falls. Injuries occur because of the forces sustained during a rapid change in velocity (deceleration)...The goal of pre-hospital care is immediate stabilization and transportation. This is achieved through...immobilization of the patient, and immediate transport...to the closest appropriate medical facility..." . Cross refer F684, Example #3. . Cross refer F689, Example #2. The following was reviewed in R5's clinical record:. 7/6/18 - R5 admitted to the facility from the hospital with visual hallucinations. . 7/30/18 and timed 8:10 AM - The facility's incident report and investigation records documented an unwitnessed fall in which R5 was found sitting next to his bed in his room and R5 did not know how he got there. Record review lacked evidence of a clinical assessment to rule out any head, neck, or spinal cord injury before moving R5 from the floor. 7/30/18 and timed 8:15 AM - The facility's incident report and investigation records documented subsequent unwitnessed fall approximately 5 minutes later, in which R5 was found on the floor sitting next to his bed in his room.	F 658	C. All licensed nursing staff has been in-serviced by the Staff Educator RN or designee on the Falls Policy and Procedure with a focus on the importance of post fall assessments and interventions. D. Fall Risk Management Audits related to post fall assessments and interventions will be conducted by the DON or designee weekly X4 until 100% compliance is achieved, monthly X3 until 100% compliance is achieved. Results will be reported to the QAPI committee monthly X3. Other: Fall P&P to be emailed to DOH as requested.	

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F 658	Continued From page 17 Record review lacked evidence of a clinical assessment to rule out any head, neck, or spinal cord injury before moving R5 from the floor. 7/30/18 and timed 1:10 PM - The facility's incident report and investigation records documented a subsequent unwitnessed fall, this time in the shower room, in which R5 was found sitting in front of the chair and R5 replied he went in the room was looking for the door to go home. Record review lacked evidence of a clinical assessment to rule out any head, neck, or spinal cord injury before moving R5 from the floor. The facility failed to provide care and services that met professional standards of quality when the facility failed to consider head and/or neck injury after R5's unwitnessed falls and lack of clinical assessments. 8/6/18 at approximately 6:00 PM - An interview with E2 (DON) confirmed the above findings. 8/7/18 at approximately 3:35 PM - During an interview with E6 (RN, UM), the findings were confirmed. Findings were reviewed with E1 (NHA) and E2 on 8/8/18 beginning at approximately 3:15 PM.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 684		10/14/18

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F 684	Continued From page 18 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, interview, review of facility's policy and procedures, and review of medical references, it was determined that the facility failed to ensure 3 (R4, R!, R5) out of 16 sampled residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan. R4 was admitted to the facility and was ordered medications to be administered and the facility failed to ensure medications and supplements were administered. In addition, the facility failed to identify a change in condition, resulting in delay of notification with R4's attending physician. For R1, medications to treat high blood pressure were administered even when the resident's blood pressure was low. The blood pressure was not repeated nor the provider contacted to determine whether the medication should be administered. R5 had multiple unwitnessed falls and the facility failed to conduct neurological assessments. Findings include: 1. Cross refer F755. Cross refer F760. The following was reviewed in R4's clinical record: 4/27/18 at 7:00 PM - R4 was admitted to the facility from an acute care hospital following treatment for urinary tract infection. R4 had additional diagnoses including primary adrenocortical insufficiency.	F 684	A. R4, R1 and R5 have been discharged from the facility. No corrective action can be taken. B. A medication audit was completed of all new and re-admissions within the past 30 days to determine availability of medications to those residents. For any resident identified as having unavailable medication, the contracted Pharmacy was notified and the medications were immediately delivered to the facility. An audit was completed on Residents receiving high blood pressure medications without protocols. Parameters/protocols were ordered and implemented as indicated by the physician. All new falls are reviewed in AM meeting to ensure neurological assessments are initiated for unwitnessed falls or falls with head trauma. C. All licensed nursing staff has been in-serviced the by the RN Staff Educator or designee on the protocol for ordering medications upon admission and readmission including significant medications at the time of admission, Mediprocity utilization, Omnicell utilization, emergency back-up pharmacy and STAT ordering and medication algorithm. Orders will be placed timely with the	

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F 684	Continued From page 19 4/27/18 and timed 11:23 PM - Nurses Note (NN), by E13 (RN), documented that R4 was alert to person, place and time, denied pain, respiration easy and unlabored. 4/27/18 - Admission orders and correlating electronic Medication Administration Record (eMAR), documented the following medications and supplement, as well as the scheduled times of administration: - Allupurinol 300 mg. daily for treatment of gout and timed 8:00 AM. - Famotidine 20 mg. daily for treatment of gastroesophageal reflux and timed 8:00 AM. - Fenofibrate 145 mg. daily and at bedtime for treatment of hyperlipidemia, timed 8:00 PM. - Folic Acid 1 mg. daily for nutritional supplementation and timed 8:00 AM. - Lasix 20 mg. daily for edema timed 8:00 AM. - Potassium Chloride Extended Release 20 meq. daily for nutritional supplement timed 8:00 AM. - Vascepa 1 gm. daily for the treatment of hyperlipidemia and timed for 8:00 AM. - Glucerna 1.2 calorie liquid, 1 can as a nutritional supplement timed at 8:00 AM and 8:00 PM. 4/27/18 - eMAR lacked evidence that Fenofibrate, scheduled to be administered at bedtime was administered. 4/28/18 and timed 5:55 AM - NN documented R4 was alert, oriented to person, place and time, very pleasant, vital signs stable, no confusion, no complaints of pain or discomfort. 4/28/18 at 8:00 AM - eMAR lacked evidence that the scheduled 7 different medications were administered, including Famotidine, Fenofibrate,	F 684	contract pharmacy to ensure medications will arrive on the next scheduled three (3) delivery sweeps daily for weekdays and two (2) on weekends. A secured tracking and communication tool, Mediprocity (24/7 hours) will be used for communication purposes between the pharmacy and the facility nursing personnel to ensure timely delivery of medications for all residents. Immediately needed significant medications will be obtained, if available, from the Omnicell a one-time dispense system located in the facility. The emergency back-up pharmacy will also be utilized to obtain the medication should they not arrive on the next first delivery sweep. An algorithm will be developed and the licensed personnel will be trained to follow the algorithm protocol to secure delivery and ensure administration of medication timely. In the event medications do not arrive, due to unforeseen circumstances or beyond facility control, medications including significant medications will be ordered STAT from the emergency back-up pharmacy and the physician will be notified. Licensed nursing staff have been in-serviced by the Staff Development RN on blood pressure monitoring and protocols for hypertension medications and on the Falls Policy and Procedure with a focus on the importance of neurological checks for unwitnessed falls or falls with head trauma. D. . Unit managers and RN supervisors	

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F 684	Continued From page 20 Folic Acid, Potassium Chloride ER, Vascepa, Glipizide, and Glucophage. In addition, the nutritional supplement, Glucerna was not administered. Review of the Omnicell [stock medications] content list revealed the Potassium Chloride was available on the unit. 4/28/18 and timed 1:33 PM - NN, by E9 (LPN) documented R4 with confusion, verbal at times. Vital sign 130/80, P 91, T 98.8F, R 22 and 94% pulse ox on 2 liters of oxygen. Resident became short of breath at beginning of shift, pulse ox 80% and with increase work of breathing. Placed on concentrator on 2 liters, noted effective 95%. Resident remains full code, however, daughter coming in later this afternoon to sign paperwork and possibly discuss code status change. Incontinent of bowel and bladder. Resident with poor oral intake, staff assisting with meals and awaiting delivery of meds from pharmacy. Physician and family aware. 8/1/18 at 2:30 PM - An interview E9 was conducted. E9 related that she was uncertain of R4's baseline, related to his orientation, thus, failed identify the change of condition, from being alert and oriented to person, place, and time during the past two shifts. E9 verbalized that R5 became short of breath at the beginning of the 7:00 AM - 3:00 PM shift, with noted use of chest muscles as he inhaled and exhaled. E9 related that she contacted a medical provider and obtained an order for oxygen as well as informing the medical provider of the unavailability of all the medications. E9 did not recall the time of the call but indicated that she communicated to the medical provider that R4's prescribed	F 684	will conduct a medication review/audit on each admission/readmission every shift to ensure medications are delivered and administered as ordered. The DON and/or NHA will be notified of any significant medications not delivered. DON or designee will review audits daily for 1 month until 100% compliance is achieved x 3, then weekly x 4 until 100% compliance is achieved x 3, then monthly x 3 until 100% compliance is achieved x 3. Results will be reported to the QAPI Committee monthly X4. New admissions with hypertension medications and new orders for hypertension medications will be audited weekly x 4 the monthly x 2 until 100% compliance is achieved x3. Fall Risk Management Audits related to neurological checks will be conducted by the DON or designee weekly X4, the monthly X2 and until 100% compliance is achieved X3. All audit results will be reported to the QAPI committee monthly X3.	

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F 684	Continued From page 21 medications were not available to be administered. E9 related that no new order was obtained, including a hold older from the medical provider on call. E9 verbalized family member of at bedside during day shift and family expressed concerns with resident's declining status, thus, R4's attending physician was made aware and subsequently received an order to transfer R4 to the hospital. E9 was not able to recall the specifics related to the decline, however, E9, as documented verbalized that staff had to assist R4 for meals since R4 was unable to do so. When asked about checking availability of medications in the Omnicell, E9 verbalized oftentimes, the medications were out of stock and did not recall if E9 checked for the availability of Potassium. E9 recalled calling the pharmacy, however, was not able to related the time and the outcome of the conversation, as it related to the missing medication. When asked if the RN supervisor was informed of the unavailability of the medications, E9 reported that she did not recall. 4/28/18 and timed 15:24 PM - NN documented that R4's family was in the facility and was concerned with resident status and current decline. A telephone was placed to R4's attending physician, E38 and received an order to send R4 to the emergency room (ER) for evaluation and treatment. Ambulance arrived at 3:30-3:45 PM. 4/28/18 and timed 5:47 PM - NN documented that the medications for R4 arrived approximately 23 hours after admission. 8/6/18 at approximately 5:05 PM - An interview with E2 (DON) confirmed R4 was not administered the above medications.	F 684		

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F 684	Continued From page 22 2. Blood Pressure Medication Administration Review of R1's closed clinical record revealed: 3/13/18 - Admission to the facility with physicians' orders to obtain vital signs every shift for 3 days along with four medications to treat high blood pressure: - Diltiazem every 6 hours at 12AM, 6AM, 12PM, 6PM - Metoprolol every 8 hours at 12AM, 8AM, 4PM - Spironolactone daily at 8AM - Lisinopril daily at 8AM 3/14/18 - Review of blood pressures documented by nurses on the eMAR were 140/76, 119/81 and 134/81. March, 2018 - May, 2018 - Review of R1's blood pressures, eMAR and progress notes revealed: - 3/15/18 (9:08 AM) BP 92/39 over 20 points lower than the day prior - three 8 AM medications given. - 4/4/18 (1:04 PM): 98/57 - 12 PM medication given. - 4/12/18 (11:19 AM): 95/59 - 12 PM medication given. - 4/22/18 (11:29 AM): 92/44 - 12 PM medication given. - 5/7/18 (12:58 AM): 90/55 - two 12 AM medications given. - 5/10/18 (12:39 AM): 97/62 - two 12 AM medications given. R1 received blood pressure medication(s) when the blood pressure was lower than usual for the resident. On the days when the blood pressure	F 684		

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F 684	Continued From page 23 was under 100, there was no evidence the reading was taken again to verify accuracy. Nor was the provider contacted to determine if the medication for hypertension should be administered. 5/11/18 - Progress note documented three medications were not administered due to a low blood pressure (96/54). The BP was repeated and found to be accurate and the nurse held the medications. There was no evidence that the provider was informed of the low blood pressure or to request parameters (blood pressure needed in order to hold the drugs). 8/3/18 (10:25 AM) - Interview with E6 (RN, UM) about accessing the actual times the nurse administered specific medications, E6 informed the surveyor s/he would check into it. 8/3/18 (approximately 10:55 AM) - E6 provided the surveyor copies of the MARs displaying the four medications ordered for hypertension, however no administration time was recorded on the forms. E6 stated that the 8 AM scheduled time was the time the nurse gave the medication. E6 added if a BP was low and there was no parameter, we "just give it." 3. Neurological Assessments Cross refer F658. Cross refer F689, Example #2. The following was reviewed in R5's clinical record:. The facility's guideline titled Neurological Assessment, with revision date of 10/2010	F 684		

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F 684	Continued From page 24 indicated that this assessment would be conducted following an unwitnessed fall. 7/6/18 - R5 admitted to the facility from the hospital with diagnoses including visual hallucinations and high blood pressure. 7/6/18 - The admission Nursing Assessment documented that R5 was oriented to person and place but not to time, had both short term and long term memory problems. 7/20/18 - Admission Minimum Data Set Assessment documented that R5 was severely cognitively impaired with short and long term memory problems. 7/30/18 and timed 8:10 AM - The facility's incident report and investigation records documented an unwitnessed fall in which R5 was found sitting next to his bed in his room and R5 did not know how he got there. Record review lacked evidence of a neurological assessment. 7/30/18 and timed 8:15 AM - The facility's incident report and investigation records documented subsequent unwitnessed fall approximately 5 minutes later, in which R5 was found on the floor sitting next to his bed in his room. Record review lacked evidence of a neurological assessment. 7/30/18 and timed 1:10 PM - The facility's incident report and investigation records documented a subsequent unwitnessed fall, this time in the shower room, in which R5 was found sitting in	F 684		

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F 684	Continued From page 25 front of the chair and R5 replied he went in the room was looking for the door to go home. Record review lacked evidence of a neurological assessment. 8/6/18 at approximately 6:00 PM - An interview with E2 (DON) confirmed the above findings. 8/7/18 at approximately 3:35 PM - During an interview with E6 (RN, UM), the findings were confirmed. These findings were reviewed with E1 (NHA) and E2, on 8/8/18 at the exit conference starting at 3:15 PM.	F 684		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and review of the facility's policy and procedures as indicated, it was determined that for 2 (R5 and R6) out of 3 sampled residents investigated for falls, the facility failed to ensure that the residents' environment remained as free of accident hazard as possible. The facility failed to ensure that R6 received adequate supervision to prevent a fall. The facility failed to ensure post fall assessments	F 689	A. R5 and R6 have been discharged from the facility and no corrective action can be taken. B. An initial audit has been completed on all residents with falls over the past 30 days to determine if a post fall assessment was completed and if new interventions were appropriately ordered.	10/14/18

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F 689	Continued From page 26 were conducted in a manner that ensured the root cause of the falls could be determined and approaches initiated to prevent additional falls and/or injury for R5. Findings include: The facility's policy and procedure, titled Fall Prevention, Assessment and Management, with a date of 8/1/17, indicated the purpose was to standardize the processes in resident fall risk assessment and outline the clinical staff responsibilities in fall management and prevention. - A nurse completes a fall risk assessment on admission. - Any resident identified as being a fall risk will have immediate interventions put into place such as a fall mat, bed in low position, call bell in reach, etc. - Residents suspected of a fall without injury is placed back into bed or chair with the assistance of at least two staff members or via mechanical lift as dictated by resident condition. The nurse will implement neuro checks to observe the resident. - In the event of a fall, the following documentation are completed- a fall event, an incident investigation summary form, a post event review, investigative protocol written summary statement. - The interdisciplinary team will review the fall and will complete, as needed the following: physician's order, update care plan, CNA flow records, as well as the unit manager initiating the recommendations and communicates to the staff. 1. Cross refer F657. The following was reviewed in R6's clinical record:	F 689	Any identified concerns were addressed. All residents requesting to access to the outdoors unsupervised were evaluated by therapy to ensure they are adequately prepared for independent use of outdoor space. Clinical records updated accordingly. List of residents approved for independent outdoor use, along with their photo, updated and maintained at the front desk. C. The Fall Policy and Procedure was revised to focus on post fall assessments and interventions. All licensed nursing staff has been in-serviced by the Staff Educator RN or designee on the revised Falls Policy and Procedure. The Policy and Procedure for Resident Use of Outdoor Space was developed and implemented for residents who are not cognitively able to make the decision to go outside independently. The policy revisions outline the safety measures supporting residents to access the outdoor space through therapy assessments. Management and front desk staff have been educated by the Staff Development RN or designee. D. Fall Risk Management Audits related to post fall assessments and interventions will be conducted by the DON or designee weekly X4 until 100% compliance is achieved, the monthly X3 and until 100% compliance is achieved. Results will be	

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F 689	Continued From page 27 4/8/18 - R6 was admitted to the facility for rehabilitation after being hospitalized. 4/9/18 - Care plan initiated for at risk for falls due to decreased mobility, but did not include "may not go outside unattended." 4/9/18 - Occupational Therapy Evaluation: Patient presented with decreased functional activities of daily living performance and decreased functional mobility. Complexities/co-morbidities impacting therapy included complicated medical history, multiple diagnoses and unstable medical condition. Patient presenting with decreased bilateral upper extremity strength, decreased activity tolerance/endurance. . . 4/23/18 - Psychiatric Evaluation: E35 (Psychiatrist) wrote the patient was alert and oriented to self, confused about place and time. Memory was impaired. Insight and judgment was fair. Assessment: Dementia and major depression. 5/4/18 at 10:15 AM - E31 (Business Office Manager) witness statement: I was on the phone in my office when I noticed R6 falling out of his wheelchair. He was self-propelling and his left front wheel went off the curb, causing his wheelchair to fall to the left. R6 fell on his left side and hit his head on the left side. His left arm was behind his back when he hit the ground. I immediately interrupted morning meeting to have a nurse respond. I called 911 to have an ambulance respond. 5/4/18 at 11:03 PM - Nursing Note: Resident return from hospital around 5:00 PM, after a fall. Cat scan and cervical spine (special diagnostic	F 689	reported to the QAPI committee monthly X3. An audit will be completed on all residents assessed by therapy to go out of doors to include: photo posting, care plan, contracts, physician orders, therapy assessment. Audits will be completed weekly x 4 until 100% compliance is achieved, the monthly X 3 until 100% compliance is achieved. Results will be presented to the QAPI committee monthly X4.	

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F 689	Continued From page 28 tests) showed no fracture ... 5/9/18 - Facility follow-up to state agency: Resident had witnessed fall from wheelchair and hit his head. Resident sent to Emergency Department for evaluation and returned same day with all scans negative. 5/10/18 - Revisions to Care plan for at risk for falls: Interventions added to send to Emergency Department for evaluation and therapy to screen upon return, but did not include "may not go outside unattended". 8/6/18 at 11:00 AM - Interview: with E34 (Receptionist) stated that on 5/4/18 when R6 fell, she did not realize he had gone outside unattended in his wheelchair. Now the front door is locked and she has a button at her desk to unlock the front door. Also, she now posts the names and photos of all the residents that have been cleared to go outside unattended. 8/6/18 at 11:40 AM - Interview: E33 (Physical Therapist) stated that for residents to be able to go outside unattended therapists must evaluate and clear them to be safe. If a resident is cleared, they will be put on a list of residents who may go outside unattended. E33 stated R6 was not safe to go outside unattended and was not on the list to go outside unattended. 8/6/18 at 11:45 AM - Interview: E8 (RN, UM) confirmed that R6 was not safe to go outside unattended on 5/4/18 when he fell. The facility failed to ensure that R6 received adequate supervision to prevent a fall. 2: Cross refer F585.	F 689		

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F 689	Continued From page 29 Cross refer F658. Cross refer F684, Example # 3. The following was reviewed in R5's clinical record: 7/6/18 - R5 was admitted to the facility from the hospital after having his right above the knee amputation surgery. R5 had diagnoses including visual hallucinations and hypertension (high blood pressure). 7/6/18 - The admission Nursing Assessment documented that R5 was oriented to person and place but not to time, had both short term and long term memory problems. 7/6/18 - A Fall Risk Evaluation failed to include R5 prescribed medications for treatment of high blood pressure and treatment of psychoactive condition and R5 was assessed as moderate risk with a score of 7, thus, failing to accurately assess R5's risk for falls. 7/7/18 - A care plan, for risk for fall, due to poor safety awareness, with fall on 7/7/18 was initiated. The goal was to minimize risk for injury related to fall. Interventions included: - Assess for fall risk on admission, quarterly, and as needed. - Encourage and assist as needed to wear proper non slip footwear. - Evaluate effectiveness and side effects of psychotropic drugs with physician for possible decrease in dosage/elimination of medication. - Have commonly used articles within easy reach. - Reinforce need to call for assistance. - Place appropriate call bell within reach. 7/7/18 and timed 00:45 AM - The facility's incident	F 689		

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F 689	Continued From page 30 report and investigation records documented R5 was found sitting on the floor next to the bed in the resident's room and R5 stated " ... he was trying to transfer from bed to chair, slide (sic) and fall (sic). Denied hitting head." This report documented that R5 had no injury and both the attending physician and the family member were notified. 7/7/18 and timed 5:19 AM - NN documented R5 was alert with confusion, which was his baseline with no apparent injury, the right below the knee amputation dressing was intact and neurological assessments were initiated. The IDT (interdisciplinary team) fall review documented interventions of fall mats and low bed, which were initiated and R5 was to be screened by therapy. 7/8/18 - A new approach to check on resident every 30 minutes was to be implemented due to R5's poor safety awareness and the staff documented this on the Every 15 minutes Resident Monitoring Form, which was initiated on 7/8/18 at 3:00 PM through 7/17/18. Record review lacked evidence of the reassessment of the adequate supervision and monitoring. Beginning on 7/18/18, the additional supervision in the form of checking the resident every 30 minutes was no longer a fall prevention approach. It was unclear why this approach was discontinued. 7/11/18 - A Resident/Family Grievance Report documented, that interested family member of R5, FM1 and FM2, had expressed multiple concerns including the apparent injury sustained due to the above fall on 7/7/18 and that the facility "Did not care plan quick enough to prevent the fall." The facility's investigated both of these	F 689		

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F 689	Continued From page 31 complaints and findings included that R5 did not have any injury from the 7/7/18 fall and the facility did complete the comprehensive care plan within the required timeframe. 7/12/18 - A subsequent IDT note indicated, "will encourage the resident to call for assistance. No new interventions at this time." Although R5 was care planned for at risk of fall due to poor safety awareness, had both short and long term memory problem, the IDT Fall Review resulted in encouraging the resident to call for assistance. 7/28/18 and timed 2:53 PM - The facility's incident report and investigation records documented subsequent unwitnessed fall in which R5 was found sitting on the floor removing his dressing from his right BKA and when asked R5 states he was trying to get to the bed to help out his soldier friend. R5 denied hitting his head. IDT Fall Review revealed, despite continued evidence of poor safety awareness, the plan was for R5 to be encouraged to wear non skid socks and to encourage him to ask for assistance. There were no new approaches to prevent fall. 7/28/18 - Fall Risk Evaluation documented a score of 16 for High risk for falls. Record review lacked evidence of new approaches to prevent accident. 7/28/18 and timed 6:49 PM - The facility's incident report and investigation records documented a subsequent unwitnessed fall in which R5 was found sitting on the floor. When questioned why he was on the floor, he states that he was not on the floor and that he was trying to find a way out of here. The investigation failed to include witness statement by the assigned CNA, E41, to	F 689		

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F 689	Continued From page 32 conduct a thorough investigation and to complete a root cause of the reason for the fall, and lack of new approaches to prevent a fall. 7/30/18 - IDT Fall Review documented R5 was alert with confusion and the plan was to evaluate for anti roll backs for the manual wheelchair. 7/30/18 and timed 8:10 AM - The facility's incident report and investigation records documented subsequent unwitnessed fall in which R5 was found sitting next to bed and R5 did not know how he got there. The investigation failed to include witness statement regarding who found the resident, a statement from the assigned CNA, E42, to conduct a thorough investigation and to complete a root cause of the reason for the fall, and lack of new approaches to prevent fall. 7/30/18 and timed 8:15 AM - The facility's incident report and investigation records documented subsequent unwitnessed fall approximately 5 minutes later, in which R5 was found on the floor sitting next to his bed in his room. The investigation failed to include witness statement regarding who found the resident, a statement from the assigned CNA, E42, in order to conduct a thorough investigation and to complete a root cause of the reason for the fall, and lack of new approaches to prevent fall. 7/30/18 and timed 1:10 PM - The facility's incident report and investigation records documented a subsequent unwitnessed fall, this time in the shower room, in which R5 was found sitting in front of the chair and R5 replied he went in the room and was looking for the door to go home. The investigation failed to include witness statement regarding who found the resident, a	F 689		

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F 689	Continued From page 33 statement from the assigned CNA, E42, to conduct a thorough investigation and to complete a root cause of the reason for the fall, and lack of new approaches to prevent a fall. 7/30/18 - IDT Fall Review documented R5 alert with confusion with poor safety awareness and current interventions remain appropriate. Psychiatry consult pending. Despite three falls on 7/30/18, the facility failed to identify any new approaches to prevent a fall. 7/30/18 - A Psychiatry Consultation documented the reason R5 was seen was for hallucinations, delusional, and tried to fall (sic) on his own. The patient had two falls, one fall when he was trying to help his soldier friend and he had a fall; and the second time, he was trying to get himself out of the facility and he fell. R5 was confused, disoriented to place and time, with some visual hallucinations off and on. A plan was to start R5 on a new anti-psychotic medication twice a day to help with delusions (false beliefs) and will follow-up for mood and medications. 8/6/18 at approximately 6:00 PM - An interview with E2 (DON) confirmed the above findings. 8/7/18 at approximately 3:35 PM - During an interview with E6 (RN, UM), the findings were confirmed. Findings were reviewed with E1 (NHA) and E2 on 8/8/18 beginning at approximately 3:15 PM.	F 689		
F 695 SS=K	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including	F 695		10/14/18

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F 695	Continued From page 34 tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, interviews, review of the facility's polices and procedures, review of hospital records, and review of other facility documentation as indicated, it was determined that the facility failed to ensure emergency equipment was available for accidental extubation for 2 (R14 and R15) out of 2 active residents in the sample with tracheotomies (trach). The lack of available emergency equipment, in addition to the lack of competent trained staff in tracheostomy care posed an immediate jeopardy (IJ) situation to residents with tracheotomies. The IJ was identified on 8/3/18 at 1:50 PM and abated on 8/4/18 at 10:00 AM. For one (R1) out of 1 tracheostomy resident closed record review the facility failed to implement measures to prevent an unplanned removal of an unhealed tracheostomy tube two days after the resident had previously pulled out the tracheostomy tube. R1 sustained harm while experiencing shortness of breath and distress. Although R1 was not capable of verbalizing due to an intellectual disability, R1 became combative while the tube remained out and the stoma closed until the EMS arrived. Not being able to take full breaths contributed to R1's fear, anxiety, and pain. Findings include:	F 695	A. R14 and R15 immediately had emergency equipment placed at bedside. R1 was discharged from the facility, no corrective action can be taken. B. An audit was completed on all residents with tracheostomies. All residents with tracheostomies have the appropriate tracheostomy supplies placed at bedside. Respiratory Therapist/designee in-serviced all licensed nursing staff on what to do in the event of an extubation. C. The facility Tracheostomy Policy and Procedure will be revised to accept only residents with established tracheostomies (30 days or greater). The internal admission director and external liaison will be educated on the new policy for accepting tracheostomies. The DON will review all referrals with tracheostomies prior to admission to determine if there are any pre-existing behaviors or circumstances present that would increase self or accidental extubation. All new admissions with established tracheostomies will be assessed by nursing for behaviors related to self	

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F 695	Continued From page 35 1a. Emergency Equipment The facility's policy and procedure, titled Tracheostomy Care, with the most recent revision date of 8/13 indicated a replacement tracheostomy (trach) tube must be available at the bedside at all times. In addition, a suction machine, supply of suction catheters, exam and sterile gloves, and flush solution must be available at bedside at all times. 8/3/18 at approximately 1:50 PM - An observation of R15 was conducted with E13 (RN) and confirmed R15's room did not have a spare trach tube. Subsequently, E2 (DON) was informed of the lack of the trach tube and E2 proceeded to central supply room, where the Shiley brand #6 trach tubes were located. E2 brought the trach tube and placed it at R15's bedside at 2:10 PM. 8/3/18 at approximately 2:50 PM -Interview with R14, a cognitively intact (per MDS Assessment dated 6/20/18) resident, who stated her trach was inserted in 2010 and was a size 6. Surveyor observed a new Shiley brand #6 trach tube in the third dresser drawer. 8/6/18 (9:15 AM) - Observation of the spare trach revealed a different Shiley brand #6 XLT (extra long) trach was in the dresser drawer. 8/6/18 at 10:46 AM - Interview with E2 (DON) confirmed the correct XLT trach was placed at the bedside Saturday morning before talking with the surveyor. E2 confirmed the XLT trach tube was available in the stock room. 1b. Competent trained staff	F 695	extubation and known accidental extubation. These newly admitted residents with tracheostomies will be observed by nursing over a 72 hour timeframe to identify any behaviors or unusual circumstances that would lead to self extubation or accidental extubation. Any residents observed with the above behaviors or unusual circumstances will have an immediate 1:1 initiated, will be immediately stabilized if applicable, and transferred to an acute care setting for evaluation. All residents with tracheostomies will have physician orders reflected on the TAR to check placement of emergency equipment at bedside during each shift. Licensed nursing personnel will be educated on checking the emergency supplies at bedside during each shift. All FT/PT license personnel have been in-serviced on tracheostomy emergency, oxygenation and reinsertion with competencies. All licensed new hires will be trained on the same during new hire orientation. . D. The DON or designee will conduct audits on the documentation by nursing on 72 hours observations data for any newly admitted resident with a tracheostomy for behaviors related to self extubation and known accidental extubation. Audits will be conducted daily x 1 month until 100% compliance is achieved, then weekly x 4 until 100% compliance is achieved then monthly x 1 until 100% compliance is achieved. Additionally, the DON or designee will conduct equipment checks weekly X4	

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F 695	Continued From page 36 The facility's policy and procedure (P & P), titled Emergency displacement of trach tube, with an effective date 3/17 was reviewed. The P & P lacked evidence of signatures of the Medical Director, Administrator, Respiratory Therapist, Director of Nursing, and the RN Staff Developer. The P & P indicated that RN may attempt to reinsert trach tube, however, the P & P failed to indicate whether a completed competency was required prior to attempting an insertion. 8/3/18 at 2:50 PM - An interview with E17 (RRT) revealed that reinsertion of a trach tube should be completed by a competent RN. In addition, the competency re-evaluation was to be conducted annually, E17 related that her recollection was that the most recent annual was completed in March 2017. The subsequent annual competencies of current staff was due in March 2018. This was not completed, however, due to E17's planned absence. E17 related that she would forward the surveyor the evidence of the in-service record. 8/3/18 at approximately 2:55 PM - Staff observation and monitoring was initiated, to ensure R14 and R15 trach tubes were not dislodged. 8/3/18 at 3 PM - Interview with E1 (NHA) and E4 (ROM) was conducted and they were advised that the lack of emergency equipment and lack of competent trained staff for insertion of a tracheostomy tube was an Immediate Jeopardy citation. 8/3/18 at approximately 3:15 PM - E17 (RRT) initiated education and competency evaluation for the first two RNs, the day shift supervisor and the	F 695	until 100% compliance is achieved then monthly X3 and until 100% compliance is achieved. Results will be reported to the QAPI committee monthly X3.	

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F 695	Continued From page 37 evening shift supervisor. At the completion of their in-service, both returned to the floor at 3:30 PM. 8/3/18 at 3:30 PM - Observation and monitoring of R14 and R15 was terminated. 8/3/18 at approximately 5:00 PM - E2 (DON) reported that, in consultation with E29, facility's Medical Director, and E17(RRT), the facility decided to revise the above P & P to include, allowing all licensed nurses, who have completed education and competency to reinsert a trach tube. Surveyor was provided a revised P & P dated 8/18, with signatures of E29, E1(NHA), E17, E2(DON), and E7 (SD) indicating the above changes. 8/4/18 at approximately 10:00 AM - The facility produced evidence that 48% of all licensed staff had been educated reinsertion, thus, IJ was abated. The facility failed to ensure that: -appropriate size trach tubes were available at the bedside for residents with tracheotomies; -staff were trained and competent in providing care when dislodgement of the trach tube occurs. Findings were reviewed with E1 (NHA) and E2 (DON) at the exit conference on 8/8/18 beginning at 3:15 PM. 2. Review of R1's closed clinical record revealed: 3/13/18 - Admission to the facility with multiple diagnoses including respiratory failure, tracheostomy, and significant intellectual disability.	F 695		

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F 695	Continued From page 38 3/13/18 - Physicians' orders included: - Trach #6 Shiley [brand]. Note: All trach residents must have the same size trach and the next size down at bedside for emergencies. Respiratory Therapist to change trach tube monthly. - Oxygen by trach collar. When in room oxygen by concentrator (oxygen machine) on 2 L continuous to keep oxygen level in blood (pulse ox) at least 92%. When out of room oxygen (oxygen tank) use 8 L PRN if pulse ox under 92%. 3/14/18 - Care plan for respiratory impairment related to . . . history of chronic respiratory failure . . . tracheostomy. Interventions included: - Evaluate lung sounds and vital signs as needed, report abnormalities to physician. - Notify physician and family/responsible party of changes in respiratory condition. - Observe for and report adverse changes in respiratory rate, cough, respiratory effort and sputum color / consistency; observe for and report ineffective breathing patterns. 4/25/18 - Interagency Clinical Status Information (form sent with the resident when sent to the hospital) included, at 9:15 AM, R1's oxygen level was 97%, heart rate 102, BP 124/92. This form documented that R1 experienced shortness of breath and agitation and that the physician and guardian were notified at 9:08 AM. The time the resident left the facility by 911 ambulance was not recorded. 4/25/18 (9:59 AM) - Nursing note by E6 (RN, UM) "Resident pulled trach out resident sent to ER for evaluation." This RN did not include the time the trach was discovered being out or R1's	F 695		

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F 695	Continued From page 39 respiratory assessment including oxygenation level in the clinical record. 4/25/18 - Emergency room provider notes documented R1 was cyanotic (grey / blue color from lack of oxygen) and the oxygen level was very low in the 80s when EMS arrival at the facility. After endotracheal tube (ET) placement into the trach site opening by EMS the resident's oxygenation level rose to 100% and shortness of breath improved. R1's upper extremities were restrained and the ET tube was removed and replaced with a Shiley #6 with a cuff that was inflated (balloon to assist in keeping trach in place). 4/25/18 (6:33 PM) - Progress note "Resident returned to facility at approximately 4:30 PM from the ER with trach in place with blood all over front neck area; bright red with dark brown, copious amount of sputum present with bright red blood mixed. Resident unable to state if in pain. Resident very combative and resistant to care and treatment at this time. Nursing was able to complete suctioning and trach care with difficulty, will continue to monitor." Due to R1's intellectual impairment, it was unclear if the combativeness and resistance to care was the result of pain, fear and / or anxiety resulting from the recent EMS and ER experience. 4/26/18 - Care plan for Resistive / Noncompliant with trach related to: disbelief in value of treatment initiated with the goal Dignity will be preserved through neat appearance and clean clothing. Interventions: allow for flexibility in ADL routine to accommodate mood, preferences and	F 695		

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F 695	Continued From page 40 customary routine; check for unmet needs (toilet, hunger, fatigue, thirst); observe for and report side effects of medications; offer choices to enhance sense of control; psychiatry consult as ordered. The newly-added care plan problem above did not address R1's removal of the trach tube, nor did it include interventions the facility would implement to prevent repeated removal of the trach tube. 4/27/18 (6:10 PM) - Nursing note by E14 (LPN), "Resident pulled trach out and then became very combative, unable to complete full set of vital signs at this time due to combativeness." Oxygen level 93% and heart rate 85, "pain status unknown due to she is Nonverbal, Supervisor notified and present, MD on site and notified, gave new order to send out via 911 for eval / treat [evaluation / treatment], Caregiver on file called and notified, she left this facility at approximately 1810 pm" [6:10 PM]. The resident's trach was pulled out again on 4/27/18, two days after the previous time on 4/25/18. R1's distress and combativeness may have been due to shortness of breath, anxiety, fear and / or pain from the inflated cuff being pulled through the neck opening. 4/27/18 - Emergency room provider notes documented R1 pulled out the trach tube and was last seen at the hospital "two days ago for the same." Resident non-verbal, not answering questions with "mild blood surrounding tracheostomy site" with no surrounding redness or signs of infection. BP low at 84/51. Chest x-ray revealed pneumonia and R1 was admitted	F 695		

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F 695	Continued From page 41 to the hospital. 5/2/18 (10:38 PM) - Nursing note included that R1 returned from the hospital at 4:20 PM with redness under trach site and oxygen level 95%. 8/2/18 (3:26 PM) - Interview with E14 (LPN) about the trach removal incident on 4/27/18 when the LPN documented the removal of the trach. E14 stated s/he did not see the resident remove the trach since s/he was in another resident's room E14 indicated s/he documented the findings as relayed by others. When asked if there was an attempt to reinsert the trach, the nurse stated, "I didn't try to reinsert since I am an LPN." 8/2/18 (3:30 PM) - Interview with E6 (RM, UM) to inquire if a reinsertion attempt was made. E6 stated there was a trach at the bedside but no reinsertion attempt was made" since it was a newer trach and it immediately closed." (referring to the hole in the front of the neck). 8/3/18 (approximately 3:00 PM) - Interview with E2 (DON) confirmed no root cause analysis was completed after either unplanned trach extubation (resident removed trach tube) to determine strategies to prevent reoccurrence. The facility failed to identify and implement measures to prevent R1 from removing the tracheostomy tube after the resident pulled it out on 4/25/18. R1 experienced harm as evidenced by shortness of breath, distress / anxiety related to the removal and reinsertion of the tracheostomy tube on 4/27/18. R1 became agitated and combative, by striking out at staff. Findings were reviewed with E1 (NHA) and E2	F 695		

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F 695	Continued From page 42 (DON) at the exit conference on 8/8/18 beginning at 3:15 PM.	F 695		
F 730 SS=B	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to ensure performance appraisals were completed at least every 12 months for 6 (E20, E21, E22, E23, E24 and E25) out of 6 sampled CNAs. Findings include: Review of the latest performance appraisals for 6 randomly selected CNAs revealed the following hire date and (last performance appraisal date): - E20: 3/14/16 (6/15/17) - E21: 4/1/09 (none) - E22: 3/18/09 (7/6/17) - E23: 3/19/12 (2/9/17) - E24: 1/21/14 (6/26/18) - E25: 4/25/11 (6/21/17) E1 (NHA) confirmed the inability to locate any performance appraisals for E21 and that rest of the appraisals were not completed timely. This findings was reviewed with E1 and E2 (DON) during the exit conference on 8/8/18 beginning at 3:15 PM.	F 730	A. No residents were affected by this deficient practice. E20, E22, E23, E24 and E25's reviews were completed at the time of survey but not within the timeframe. E21's performance review was completed. B. No residents have been affected by this deficient practice. An audit of nurse aides (CNA's) performance reviews was completed. Any outstanding performance evaluations have been completed. C. The Ultipro Payroll System will automatically generate a monthly reminder of all performance reviews coming due one month prior to due date. The reminder will be sent to the NHA, DON and HR Director. The HR Director will inform the appropriate department heads of due reviews and follow up on the progress. An in-service will provided by the HR Director or designee to the department managers on completing	9/18/18

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F 730	Continued From page 43	F 730	performance reviews. D. An audit will be completed by the HR Director or designee monthly X3 and until 100% compliance is achieved. The results will be reported to the QAPI Committee monthly X3.	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 755		10/14/18

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F 755	Continued From page 44 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of facility documentation it was determined that for 1 (R4) out of 3 residents sampled, the facility failed to ensure that the pharmaceutical services provided included the accurate dispensing and administration of medications. Findings include: .Cross refer F684, Example #1. Cross refer F760. 1. The following was reviewed in R4's clinical record 4/27/18 at 7:00 PM - R4 was admitted to the facility from an acute care hospital. 4/27/18 - Admission orders and correlating electronic Medication Administration Record (eMAR), documented the following medications and supplements, as well as the scheduled time(s) of administration: - Allupurinol 300 mg. daily for treatment of gout and timed 8:00 AM. - Norvasc 5 mg. daily for treatment of high blood pressure and timed 8:00 AM. - Digoxin 125 mcg. daily for chronic atrial fibrillation and timed 8:00 AM. - Famotidine 20 mg. daily for gastroesophageal reflux disease and timed 8:00 AM. - Fenofibrate 145 mg. daily and at bedtime for treatment of hyperlipidemia, timed 8:00 PM. - Fludrocortisone Acetate 0.1 mg. daily for treatment of primary adrenocortical insufficiency and timed 8:00 AM. - Folic Acid 1 mg. daily for nutritional supplementation and timed 8:00 AM.	F 755	A. R4 has been discharged from the facility. No corrective action can be taken. B. A medication audit was completed of all new and re-admissions within the past 30 days to determine availability of medications to those residents. For any resident identified as having unavailable medication, the contracted Pharmacy was notified and the medications were immediately delivered to the facility. C. All licensed nursing staff has been in-serviced the by the RN Staff Educator or designee on the protocol for ordering medications upon admission and readmission including significant medications at the time of admission, Mediprocity utilization, Omnicell utilization, emergency back-up pharmacy and STAT ordering and medication algorithm. Orders will be placed timely with the contract pharmacy to ensure medications will arrive on the next scheduled three (3) delivery sweeps daily for weekdays and two (2) on weekends. A secured tracking and communication tool, Mediprocity (24/7 hours) will be used for communication purposes between the pharmacy and the facility nursing personnel to ensure timely delivery of medications for all residents. Immediately needed significant medications will be obtained, if available, from the Omnicell a	

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F 755	Continued From page 45 - Lasix 20 mg. daily for edema timed 8:00 AM. - Potassium Chloride Extended Release 20 meq. daily for nutritional supplement timed 8:00 AM. - Aldactone 25 mg. daily for edema timed 8:00 AM. - Coreg 12.5 mg. twice a day for treatment of high blood pressure and timed at 8:00 AM and 5:00 PM. - Vascepa 1 gm daily for the treatment of hyperlipidemia and timed for 8:00 AM. - Eliquis 2.5 mg. twice a day for treatment of atrial fibrillation and timed at 8:00 AM and 8:00 PM. - Glipizide 5 mg. by twice a day for treatment of diabetes and timed at 8:00 AM and 6:00 PM. - Glucerna 1.2 calorie liquid, 1 can as a nutritional supplement timed at 8:00 AM and 8:00 PM. - Glucophage 1000 mg. for treatment of diabetes timed at 8:00 AM and 6:00 PM with meals. - Hydrocortisone 20 mg. for treatment of adrenocortical insufficiency and timed at 8:00 AM and 8:00 PM. 4/27/18 - eMAR lacked evidence that the following medications scheduled to be administered at bedtime was administered: Fenofibrate, Eliquis, and Hydrocortisone. 4/28/18 at 8:00 AM - eMAR lacked evidence that the scheduled 15 daily medications were administered, including Norvasc, Digoxin, Famotidine, Fenofibrate, Fludrocortisone, Folic Acid, Lasix, Potassium Chloride ER, Aldactone, Coreg, Vascepa, Eliquis, Glipizide, Glucophage, and Hydrocortisone. In addition, the nutritional supplement, Glucerna was not administered. Review of the Omnicell [stock medications] content list revealed the Carvedilol, Potassium, Digoxin, and Lasix were all available on the unit.	F 755	one-time dispense system located in the facility. The emergency back-up pharmacy will also be utilized to obtain the medication should they not arrive on the next first delivery sweep. An algorithm will be developed and the licensed personnel will be trained to follow the algorithm protocol to secure delivery and ensure administration of medication timely. In the event medications do not arrive, due to unforeseen circumstances or beyond facility control, medications including significant medications will be ordered STAT from the emergency back-up pharmacy and the physician will be notified. D. Unit managers and RN supervisors will conduct a medication review/audit on each admission/readmission every shift to ensure medications are delivered and administered as ordered. The DON and/or NHA will be notified of any significant medications not delivered. DON or designee will review audits daily for 1 month until 100% compliance is achieved x 3, then weekly x 4 until 100% compliance is achieved x 3, then monthly x 3 until 100% compliance is achieved x 3. Results will be reported to the QAPI Committee monthly X4.	

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F 755	Continued From page 46 4/28/18 and timed 5:47 PM - NN documented that the medications for R4 arrived approximately 23 hours after admission. 8/1/18 at 2:30 PM - An interview with E9 was conducted. E9 did not recall the time of the call but indicated that she communicated to the medical provider that R4's prescribed medications were not available to be administered. When asked about checking availability of medications in the Omnicell, E9 verbalized oftentimes, the medications were out of stock and did not recall if E9 checked for the availability of Digoxin, Lasix, Coreg, and Potassium. E9 recalled calling the pharmacy, however, was not able to report the time and the outcome of the conversation, as it related to the missing medications. When asked if the RN supervisor was informed of the unavailability of the medications, E9 reported that she did not recall. 8/8/18 at approximately 9:30 AM - Interview with E2 (DON) confirmed, R4 was not administered any of the medications during his confinement. 8/8/18 at approximately 3:15 PM - Above findings were reviewed with E1 (NHA) and E2.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:	F 758		9/18/18

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F 758	Continued From page 47 (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or	F 758		

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F 758	Continued From page 48 prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, interviews and review of other facility documentation, it was determined that for 1 (R5) out of 3 sampled residents who were prescribed psychotropic medications, the facility failed to ensure that medication was necessary to treat a specific condition as diagnosed and documented in the clinical record and was adequately monitored. Findings include: Cross refer F842 example #2. 1a. Review of R5's clinical records revealed the following: Lack of Abnormal Involuntary Movement Scale (AIMS) 7/6/18 - R5 was admitted to the facility with diagnoses including visual hallucinations. 7/6/18 - Admission order included an order for antipsychotic medication, Seroquel 20 mg. daily by mouth for an indication of "Other psychoactive substance abuse, uncomplicated." 7/7/18 - electronic Medication Administration Record (eMAR) documented that R5 was administered the first dose of Seroquel. Record review lacked evidence that the AIMS assessment was conducted on admission to establish a base line and to determine the presence of any adverse consequences of the antipsychotic medication.	F 758	A. R5 has been discharged from the facility. No corrective action can be taken. B. An audit was completed on all current residents utilizing antipsychotic medications to determine current monitoring with the AIMS assessment tool. Residents receiving antipsychotic medications all have an AIMS in place. Behavior monitoring sheets are in place for all residents receiving antipsychotic medication. C. Licensed staff will be in-serviced by the Staff Development RN or designee on the AIMS Guideline, assessment protocols and behavior monitoring . D. AIMS Audits and behavior monitoring will be conducted weekly X4 until 100% compliance is achieved, monthly x3 until 100% compliance is achieved. Results to be reported to QAPI Committee monthly X3.	

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F 758	Continued From page 49 7/7/18 - R5 was care planned for at risk for adverse effects related to use of antipsychotic medication; visual hallucinations and other psychoactive substance abuse, uncomplicated. The goal was that R5 would not experience signs of hallucinating or delusional thinking through the next review date of 10/29/18. The care plan's approaches included, but not limited to: - AIMS testing per facility guideline. - Attempt non-pharmacological interventions including one on one (supervision), activity, adjust room temperature, backrub, change position, give fluids, give food, redirect, remove resident from environment, return to room. - Communication: provide physical and verbal cues to alleviate anxiety, give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out staff when agitated. - Evaluate effectiveness and side effects of medications for possible decrease/elimination of physchropic (sic) drugs. - Observe mood state/behavior. - Psychiatrist consult and follow-up as needed. 8/8/18 at approximately 9:30 AM - An interview with E2 (DON) confirmed that the facility failed to complete an AIMS assessment prior to the first dose administration of Seroquel. 1b. Lack of Monitoring of Targeted Behavior 7/6/18 through 7/30/18 - Clinical record review, including Nurses Notes and eMAR lacked evidence of monitoring the targeted behavior of visual hallucination. 7/9/18 - Psychiatry Initial Consultation, by E35	F 758		

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F 758	Continued From page 50 (Psychiatrist), stated R5 denied hallucination at the time of the examination and may be secondary to some medical condition. Although R5 was receiving Seroquel daily, the consultation documented that R5 was not receiving any medication. The assessment documented a diagnosis of psychosis and the psychiatrist had no recommendation at the time of this consultation. 7/16 18 - A Psychiatry Consultation, by E35, documented the reason for the consultation was for an initial evaluation for delusion and paranoia. This consultation documented "...history of Alzheimer dementia. At the time of the consultation, R5 was alert and oriented X3, had no issues with day to day activity of life, able to convey his thoughts well, no behavior, memory fair, insight and judgement fair and diagnosis remained as psychosis and no recommendation at the time of this consultation". This consultation lacked evidence whether the psychiatrist was aware that R5 was receiving Seroquel on a daily basis. 7/29/18 and timed 2:44 PM - NN documented a family member, FM1 requested for Seroquel to be discontinued since FM1 feels it will assist R5 in becoming more alert and oriented. The nurse obtained an order to discontinue the Seroquel starting the evening of 7/29/18 and R5's family member was made aware. 7/29/18 and timed 8:00 PM - eMAR documented that the Seroquel was discontinued, thus, R5 was not administered Seroquel beginning on 7/29/18. The facility failed to identify and monitor the	F 758		

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F 758	Continued From page 51 targeted behavior for the use of antipsychotic medication, Seroquel. 7/30/18 - A Psychiatry Consultation, by E35, documented the reason R5 was seen was for hallucinations, delusional, and tried to fall on his own. The patient had two falls, one fall when he was trying to help his soldier friend and he had a fall and the second time, he was trying to get himself out of the facility and he fell. R5 was confused, disoriented to place and time, with some visual hallucinations off and on. The plan was to start another antipsychotic medication, twice a day to help with delusions and will follow-up for mood and medications. 8/8/18 at approximately 9:30 AM - An interview with E2 revealed that the facility monitored the targeted behavior on the eMAR and confirmed that the facility failed to have evidence that the targeted behavior(s) were identified and monitored, while R5 was administered Seroquel from 7/7/18 through 7/28/18. 8/8/18 at approximately 11:18 AM - A telephone call was placed to E35 and voicemail left for E35 to return call to the surveyor, however, no return call was received. Findings were reviewed with E1 (NHA) and E2 during the exit conference on 8/8/18, beginning at 3:15 PM.	F 758		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors.	F 760		10/14/18

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F 760	Continued From page 52 This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of medical literature, it was determined that the facility failed to ensure that 1 (R4) out of 3 sampled residents was free from significant medication errors. R4 was admitted to the facility and was ordered medications to be administered and the facility failed to ensure these significant medications were administered. These medications included medications to treat primary adrenocortical insufficiency (Addison's Disease), medications to treat high blood pressure, medications to treat atrial fibrillation, and medications to treat edema. This failure resulted in a change in condition, as evidenced by altered mental status of confusion at the beginning of the day shift on 4/28/18. Due to family's concern that R4 was very weak, the facility notified a medical provider at 3:45 PM and an order was obtained to transfer R4 to the hospital for emergent care. At the hospital, R4 was found to be in adrenal crisis. R4 sustained harm when he did not receive his significant medications. In addition, R4 was diagnosed and treated for pneumonia. Findings include: Adrenal crisis can occur from any of the following: - The adrenal gland is damaged due to, for example, Addison disease or other adrenal gland disease, and surgery - The pituitary is injured and cannot release ACTH - Adrenal insufficiency is not properly treated - Taking glucocorticoid medicines for a long time, and suddenly stop - Dehydration - Infection or other physical stress (https://medlineplus.gov/ency/article/000357.htm)	F 760	A. R4 has been discharged from the facility. No corrective action can be taken. B. A medication audit was completed of all new and re-admissions within the past 30 days to determine availability of medications to those residents. For any resident identified as having unavailable medication, the contracted Pharmacy was notified and the medications were immediately delivered to the facility. C. All licensed nursing staff has been in-serviced the by the RN Staff Educator or designee on the protocol for ordering medications upon admission and readmission including significant medications at the time of admission, Mediprocity utilization, Omnicell utilization, emergency back-up pharmacy and STAT ordering and medication algorithm. Orders will be placed timely with the contract pharmacy to ensure medications will arrive on the next scheduled three (3) delivery sweeps daily for weekdays and two (2) on weekends. A secured tracking and communication tool, Mediprocity (24/7 hours) will be used for communication purposes between the pharmacy and the facility nursing personnel to ensure timely delivery of medications for all residents. Immediately needed significant medications will be obtained, if available, from the Omnicell a one-time dispense system located in the facility. The emergency back-up pharmacy will also be utilized to obtain the	

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F 760	Continued From page 53 1. Cross refer F684, Example #1. Cross refer F755. The following was reviewed in R4's clinical record: 4/27/18 at 7:00 PM - R4 was admitted to the facility from an acute care hospital following treatment for urinary tract infection. R4 had additional diagnoses including primary adrenocortical insufficiency. 4/27/18 and timed 11:23 PM - Nurses Note (NN), by E13 (RN) documented that resident was alert to person, place and time, denied pain, respiration easy and unlabored. 4/27/18 - Admission orders and correlating electronic Medication Administration Record (eMAR), documented the following medications, as well as the scheduled time(s) of the administrations: - Hydrocortisone 20 mg. for treatment of adrenocortical insufficiency and timed at 8:00 AM and 8:00 PM. - Fludrocortisone Acetate 0.1 mg. daily for treatment of primary adrenocortical insufficiency and timed 8:00 AM. - Lasix 20 mg. daily for edema timed 8:00 AM. - Aldactone 25 mg. daily for edema timed 8:00 AM. - Coreg 12.5 mg. twice a day for treatment of high blood pressure and timed at 8:00 AM and 5:00 PM. - Eliquis 2.5 mg. twice a day for treatment of atrial fibrillation and timed at 8:00 AM and 8:00 PM. - Norvasc 5 mg. daily for treatment of high blood pressure and timed 8:00 AM.	F 760	medication should they not arrive on the next first delivery sweep. An algorithm will be developed and the licensed personnel will be trained to follow the algorithm protocol to secure delivery and ensure administration of medication timely. In the event medications do not arrive, due to unforeseen circumstances or beyond facility control, medications including significant medications will be ordered STAT from the emergency back-up pharmacy and the physician will be notified. D. Unit managers and RN supervisors will conduct a medication review/audit on each admission/readmission every shift to ensure medications are delivered and administered as ordered. The DON and/or NHA will be notified of any significant medications not delivered. DON or designee will review audits daily for 1 month until 100% compliance is achieved x 3, then weekly x 4 until 100% compliance is achieved x 3, then monthly x 3 until 100% compliance is achieved x 3. Results will be reported to the QAPI Committee monthly X4.	

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F 760	Continued From page 54 - Digoxin 125 mcg. daily for chronic atrial fibrillation and timed 8:00 AM. 4/27/18 - Electronic Medication Administration Record (eMAR) lacked evidence that Eliquis and Hydrocortisone, medications scheduled to be administered at bedtime were administered. 4/28/18 and timed 5:55 AM - NN documented R4 was alert, oriented to person, place and time, very pleasant, vital signs stable, no confusion, no complaints of pain or discomfort. 4/28/18 at 8:00 AM - MAR lacked evidence that the following scheduled medications were administered: - two medications to treat primary adrenocortical insufficiency: Fludrocortisone and Hydrocortisone. - two medications to treat atrial fibrillation: Eliquis and Digoxin. - two medications to treat high blood pressure: Norvasc and Coreg. - two medications to treat edema: Lasix and Aldactone. Review of the Omnicell [stock medications] content list revealed the Coreg, Digoxin, and Lasix were all available on the unit. 4/28/18 and timed 1:33 PM - Nurses Note (NN), by E9 (LPN) documented R4 with confusion, verbal at times. Vital sign 130/80, P 91, T 98.8F, R 22 and 94% pulse ox on 2 liters of oxygen. Resident became short of breath at beginning of shift, pulse ox 80% and with increase work of breathing. Placed on concentrator on 2 liters, noted effective, as the pulse ox increased to 95%. Resident was incontinent of bowel and bladder.	F 760		

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F 760	Continued From page 55 Resident with poor oral intake, staff assisting with meals and awaiting delivery of meds from pharmacy. Physician and family aware. 4/28/18 and timed 1:40 PM - a telephone order from R4's attending physician, E38 for continuous oxygen at 2 liters per minute via nasal cannula and may titrate oxygen to maintain pulse ox greater than 92%. 4/28/18 and timed 15:24 (3:24 PM) PM - NN documented that R4's family was in the facility and was concerned about the resident's status and current decline. A telephone call was placed to R4's attending physician, E38 and received an order to send R4 to the emergency room (ER) for evaluation and treatment. Ambulance arrived at 3:30-3:45 PM. Record review lacked evidence, of an RN Supervisor oversight to ensure that medications were being administered as ordered. 4/28/18 and timed 5:47 PM - NN documented that the medications for R4 arrived at the facility. This was approximately 23 hours after admission. Meanwhile, the resident experienced a change of condition and required transfer to the ER for evaluation. 4/28/18 - Review of the hospital ER records revealed, R4 arrived in the emergency room at 4:34 PM. ER note documented, that the discharge instructions from the hospital on 4/27/18 indicated to continue Hydrocortisone for Addison's Disease and R4 did not receive his chronic medication since discharge from the hospital on 4/27/18. In the ER, R4 was found obtunded with a fever of 101.9F, blood pressure	F 760		

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F 760	Continued From page 56 stable, atrial fibrillation with appropriate rate control. Chest x-ray with pleural effusion. Treatment included Hydrocortisone 100 mg. by mouth every 8 hours. 5/17/18 - Hospital discharge summary, documented a brief hospital course, which indicated R4 had fever, extreme weakness and inability to ambulate in the ER and R4 had not been receiving his renal (sic) replacement therapy. R4 was admitted and worked up found to be in adrenal crisis and started on IV antibiotic for pneumonia and there was a question of UTI. Principal diagnosis was pneumonia with adrenal crisis. 8/1/18 at 2:30 PM - An interview with E9 (LPN) was conducted. E9 related that she was uncertain of R4's baseline, related to his orientation, thus, failed to identify the change of condition, from being alert and oriented to person, place, and time during the previous two shifts. E9 verbalized that R4 became short of breath at the beginning of the 7:00 AM - 3:00 PM shift, with noted use of chest muscles as he inhaled and exhaled. E9 related that she contacted a medical provider and obtained an order for oxygen as well as informing the medical provider of the unavailability of all the medications. E9 did not recall the time of the call but indicated that she communicated to the medical provider that R4's prescribed medications were not available to be administered. E9 related that no new order was obtained, including a hold older from the medical provider on call. E9 verbalized that a family member of R4 was at bedside during day shift and family expressed concerns with resident's declining status. R4's attending physician was made aware and subsequently received an order	F 760		

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F 760	Continued From page 57 to transfer R4 to the hospital. E9 was not able to recall the specifics related to the decline. When asked about checking availability of the medications in the Omnicell, E9 verbalized that (s)he did not recall but went on to say that often the medications were out of stock. E9 recalled calling the pharmacy about the missing medications, however, was not able to relate the time and the outcome of the conversation. When asked if the RN supervisor was informed of the unavailability of the medications, E9 reported that (s)he did not recall. 8/2/18 at approximately 1:34 PM - An interview with E37 (PA) revealed, that the only option for a newly admitted resident who becomes symptomatic due to lack of medication availability would be to send the resident to the hospital. E37 related that (s)he was not the medical provider on call on 4/28/18. E37 provided the surveyor the telephone number for the medical practice's on-call service, in order for the surveyor to obtain the time(s) of the call to the medical providers and the names of the medical provider. 8/2/18 at 2:43 PM - A telephone call was placed to the medical practice's on-call service to determine the medical provider who had received the reported call from E9 (LPN) on 4/28/18 during day shift. In response to this call, the surveyor received a call from a Risk Manager, who verbalized she will attempt to obtain this information and follow-up with the surveyor. There was no follow-up call during the survey. 8/6/18 at approximately 5:05 PM - An interview with E2 (DON) confirmed that the previously documented medications were not administered to R4. E2 reported, during the current survey,	F 760		

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F 760	Continued From page 58 staff education was being conducted to educate all licensed nurses on the process to ensure acquisition of medications for all residents. The education included entering orders into the eMAR system, anticipated pharmacy delivery times, and accessing the Omnicell for available medications. Surveyor requested a written policy and procedure related to the back-up pharmacy services, however, no information was provided during the survey. The facility failed to: - Ensure that medications were on hand or obtained from the pharmacy or transferring facility prior to accepting a resident for admission. - Check stock medications after the resident's admission to determine if medications was available. - Take actions when a change of condition was noted at teh beginning of the shift until the family noted concern later that afternoon. Resulting in the resident's emergent transfer to an acute care emergency department where the resident was diagnosed with adrenal crisis with pneumonia. 8/8/18 at approximately 3:15 PM - Above findings were reviewed with E1 (NHA) and E2.	F 760		
F 835 SS=E	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 835		10/14/18

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F 835	Continued From page 59 This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and review of other facility documentation, it was determined that the facility was not administered in a manner that enabled it to use its resources effectively and efficiently to attain the highest practicable well-being of each resident. Findings include: 1. Cross refer F585. The facility failed to establish a grievance process which ensured the prompt resolution of grievances verbalized by R5's interested family members, FM1 and FM2 on 7/11/18 and on 7/23/18, by FM1. The facility's grievance documentation documented the signatures of E1 (NHA) and the designated Grievance Officer, E39, thus, administration was aware the follow-up was not with the complainants but rather with R5's responsible party, FM3. 2. Cross refer F689, Example #2. The facility failed to establish a system which ensured necessary information was obtained in a timely matter, in order to conduct a thorough investigation and identification of the contributing factors, through the root cause analysis process, related to falls experienced by R5. These failures prevented the facility from developing approaches to prevent further falls from occurring. 3. Cross refer F695, Example #1 and Example # 2. The facility failed to ensure tracheostomy tubes were available at the bedside of residents with tracheostomies, in case of accidental removal of the tube. In addition, the facility failed to ensure, staff demonstrated annual competencies for inserting a trach tube.	F 835	A. F585- R5 has been discharged from the facility. A copy of the resolution summary was mailed to the complainant on 8/27/18. F689 - R5 and R6 have been discharged from the facility. No corrective action could be taken. F695 - R14 and R15 immediately had emergency equipment placed at bedside. -No residents were affected by this deficient practice. F730 - E20, E22, E23, E24 and E25□s reviews were completed at the time of survey but not within the timeframe. E21□s performance review was completed. F943 - E18 and E19 have been trained on the Abuse Policy and Procedure. No residents were impacted by this lack of training. No employee will perform direct care without abuse training. B. F585 - A copy of the resolution summary was mailed to the complainant on 8/27/18.The grievance log audit has been completed for the past 30 days by the Director of Social Services. All grievances identified as incomplete or where the complainant was not notified has been corrected. F689 - An initial audit has been completed on all residents with falls over the past 30 days to determine if a post fall assessment was completed and if new	

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F 835	Continued From page 60 4. Cross refer F730. The facility failed to ensure annual performance appraisals were completed for 6 out of 6 CNAs. 5. Cross refer F943. The facility failed to ensure required abuse, neglect, and exploitation training was conducted for 2 out of 11 sampled staff members. 8/8/18 at approximately 3:15 PM - Above findings were reviewed with E1 (NHA) and E2 (DON).	F 835	interventions were appropriately ordered. Any identified concerns were addressed. All residents requesting to access to the outdoors unsupervised were evaluated by therapy to ensure they are adequately prepared for independent use of outdoor space. Clinical records updated accordingly. F695 - An audit was completed on all residents with tracheostomies. All residents with tracheostomies have the appropriate tracheostomy supplies placed at bedside. Respiratory Therapist/designee in-serviced all licensed nursing staff on what to do in the event of an extubation. F730 - No residents have been affected by this deficient practice. An audit of nurse aides (CNA□s) performance reviews was completed. Any outstanding performance evaluations have been completed. F943 - An educational audit was conducted on all employees to review compliance with the Abuse, Neglect and exploitation training. Any employee(s) identified as having not received the Abuse, Neglect and exploitation in-service was in-serviced. C. F585 - The social services department has been re-educated on the grievance policy and procedures, grievance form, completion of the grievance form and identified recipients of the resolution summary. F689 - The Fall Policy and Procedure was	

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F 835	Continued From page 61	F 835	revised to focus on post fall assessments and interventions. All licensed nursing staff has been in-serviced by the Staff Educator RN or designee on the revised Falls Policy and Procedure. The Policy and Procedure for Resident Use of Outdoor Space was developed on 5/18 and implemented. The policy revisions outline the safety measures supporting residents to access the outdoor space through therapy assessments. Management and front desk staff has been educated by the Staff Development RN or designee. F695 - The facility Tracheostomy Policy and Procedure will be revised to accept only residents with established tracheostomies (30 days or greater). The internal admission director and external liaison will be educated on the new policy for accepting tracheostomies. The DON will review all referrals with tracheostomies prior to admission to determine if there are any pre-existing behaviors or circumstances present that would increase self or accidental extubation. All new admissions with established tracheostomies will be assessed by nursing for behaviors related to self extubation and known accidental extubation. These newly admitted residents with tracheostomies will be observed by nursing over a 72 hour timeframe to identify any behaviors or unusual circumstances that would lead to self extubation or accidental extubation. Any residents observed with the above behaviors or unusual circumstances will be immediately stabilized and transferred	

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F 835	Continued From page 62	F 835	to an acute care setting for evaluation. All residents with tracheostomies will have physician orders reflected on the TAR to check placement of emergency equipment at bedside during each shift. Licensed nursing personnel will be educated on checking the emergency supplies at bedside during each shift. All FT/PT license personnel have been in-serviced on tracheostomy emergency, oxygenation and reinsertion with competencies. All licensed new hires will be trained on the same during new hire orientation. F730 - The Ultipro Payroll System will automatically generate a monthly reminder of all performance reviews coming due one month prior to due date. The reminder will be sent to the NHA, DON and HR Director. The HR Director will inform the appropriate department heads of due reviews and follow up on the progress. An in-service will provided by the HR Director or designee to the department managers on completing performance reviews. F943 - HR and Staff Development were in-serviced on abuse training requirement. All new hired employees are required to complete the Abuse, Neglect and exploitation training in Healthcare Academy prior to orientation. Monthly reports will be generated by the HR Director to ensure all employees are trained timely. D. F585 - Grievance compliance audits will	

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F 835	Continued From page 63	F 835	be completed by the Social Services Director or designee weekly X4 until 100% compliance is achieved, then monthly X2 until 100% compliance is achieved with results reported to the QAPI Committee monthly X3. F689 - Fall Risk Management Audits related to post fall assessments and interventions will be conducted by the DON or designee weekly X4 until 100% compliance is achieved, then monthly X3 and until 100% compliance is achieved. Results will be reported to the QAPI committee monthly X3. An audit will be completed on all residents assessed by therapy to go out of doors to include: photo posting, care plan, contracts, physician orders, therapy assessment. Audits will be completed weekly x 4 until 100% compliance is achieved, the monthly X 3 until 100% compliance is achieved. Results will be presented to the QAPI committee monthly X4. F695 - The DON or designee will conduct audits on the documentation by nursing on 72 hours observations data for any newly admitted resident with a tracheostomy for behaviors related to self extubation and known accidental extubation. Audits will be conducted daily x 1 month until 100% compliance is achieved, then weekly x 4 until 100% compliance is achieved then monthly x 1 until 100% compliance is achieved. Additionally, the DON or designee will conduct equipment checks weekly X4 until 100% compliance is achieved then monthly X3 and until 100% compliance is	

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F 835	Continued From page 64	F 835	achieved. Results will be reported to the QAPI committee monthly X3. F730 - An audit will be completed by the HR Director or designee monthly X3 and until 100% compliance is achieved. The results will be reported to the QAPI Committee monthly X3. F943- Abuse, Neglect and Exploitation compliance training audits will be completed by the HR Director or designee weekly x 4 until 100% compliance is achieved, then monthly X3 and until 100% compliance is achieved. Results will be reported to the QAPI Committee monthly X3.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		10/14/18

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F 842	Continued From page 65 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and	F 842		

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F 842	Continued From page 66 determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interviews and review of other facility documents, it was determined that for 2 (R16 and R5) out of 16 sampled residents, the facility failed to meet professional standards for accurate documentation. Findings include: Facility policy on medication administration (Revised 2012) states as follows: "4. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for instance, before and after meal orders) .... 16. If a drug is withheld, refused or given at a time other than the scheduled time, the individual administering the medication shall be coded with the corresponding eMAR chart code on the eMAR space provided for that drug and dose.... 18. As required or indicated for a medication, the individual administering the medication will record in the resident's medical record: a. The date and time the medication was administered;" Review of R16's clinical record revealed: 1a. 8/7/18 - 9:06 AM - During a random inspection on the Aspen unit for medication administration, it was observed that 2 units of Humulog insulin (medication to treat high blood sugar) was administered by E28 (LPN) in response to a blood glucose of 182, entry	F 842	A. R16, R5, R14 were discharged from the facility. No corrective action could be taken. R16, R5, and R14 were not negatively affected by this deficient practice. B. All the residents have the potential to be affected by this deficient practice. An audit was conducted on all residents with Insulins with corresponding blood glucose levels to ensure accurate documentation. Corrections were made as indicated to the clinical record. An audit was completed with a look up of 45 days pertaining to psychiatric consults by the affected practitioner. All corrections were made by the psychiatric practitioner. Psychiatric practitioner no longer practices at the facility. C. Education will be provided to the licensed staff by the Staff Development RN focusing on Medication administration compliance (2 hour window), if late, proper documentation in the clinical record, documenting timely in the clinical record and accurate documentation in the clinical record. All licensed new hires will be captured at the time of orientation for compliance. Additionally, medication administration times were reviewed and adjusted to stagger medication times to	

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F 842	Continued From page 67 recorded at 9:06 AM. 8/7/18 - approximately 9:30 AM - Review of electronic medication administration record reflects an order for "Humulog Solution 100 unit/ml (insulin lispro). Inject as per sliding scale .... subcutaneously before meals and at bedtime" with morning dose scheduled at 7:30 AM. 8/7/18 - approximately 1:00 PM - Review of R16's clinical records lacked evidence of documentation regarding late administration of insulin at 9:06 AM since it was not given within one hour of the scheduled time of 7:30 AM, although eMAR reflected this medication was given at 7:30 AM. 1b. Review of R16's clinical record revealed: 8/7/18 - 1:04 PM - Interview with E27 (CNA) reflected that R16 goes to dining room to eat meals per his/her preference. 8/7/18 - 2:11 PM - Interview with E28 (LPN) revealed that he/she obtained blood sugars immediately following report between 7:00 AM and 7:15 AM and, further, that R16, a cognitively intact resident, as evidenced by the Minimum Data Set Assessment dated 7/24/18, did not want insulin until after the resident had eaten. E28 stated that R16 typically eats 100% of meals served. E28 stated that late administration of a medication was documented only if it was given "super late". R16 consistently received his/her insulin, per preference, after eating breakfast between 9:00 AM and 9:30 AM, which still fell within "breakfast time." E28 explained that he/she does all blood sugars upon getting report because there are so many to obtain prior to	F 842	increase compliance. D. Random MAR administration compliance audits will be conducted weekly X4 until 100% compliance is achieved, then monthly x2, until 100% compliance is achieved. Random documentation compliance audits will be conducted on consultant reports for accuracy weekly X4 until 100% compliance is achieved, then monthly x2, until 100% compliance is achieved. Results will be reported to QAPI Committee X 3.	

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F 842	Continued From page 68 breakfast being served. E28 state that although R16's blood sugar was not entered into the computer until 9:06 AM, it was taken earlier and prior to him/her going to breakfast. 8/8/18 - 9:36 AM - Interview with R16, who stated that it was his/her preference to eat a meal before taking insulin. R16 said that the nurse takes his/her blood sugar, he/she eats and then he/she will take insulin if his/her blood sugar was above 120. He/She stated that he/she refuses insulin if his/her blood sugar was below 120. He/She stated that this was what he/she does at home. Based on the foregoing circumstances, it was determined that the facility failed to ensure timely and accurate documentation of medication administration and blood glucose level. Cross refer F758. 2. Review of R5's clinical records revealed the following: 7/6/18 - R5 was admitted to the facility with diagnosis including visual hallucinations. 7/6/18 - Admission order included an order for antipsychotic medication, Seroquel 20 mg. daily by mouth for an indication of "Other psychoactive substance abuse, uncomplicated." 7/9/18 - Psychiatry Initial Consultation, by E35 (Psychiatrist), indicated R5 denied hallucination at the time of the examination and may be secondary to some medical condition. Although R5 was receiving Seroquel daily, the above consultation documentation inaccurately documented that R5 was not receiving any psychoactive medication. The assessment documented a diagnosis of psychosis and the	F 842		

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F 842	Continued From page 69 psychiatrist had no recommendation at the time of this consultation. 8/8/18 at approximately 11:18 AM - A telephone call was placed to E35 and voicemail left for E35 to return call to the surveyor, however, no return call was received. Findings were reviewed with E1 (NHA) and E2 (DON) at the exit conference on 8/8/18 beginning at 3:15 PM.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880		9/18/18

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F 880	Continued From page 70 procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 71 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, interviews and review of other facility documentation it was determined that the facility failed to ensure transmission-based precautions were followed for 2 (R7 and R14) out of 2 residents sampled on contact precautions. Findings include: Facility Policy entitled "Isolation - Categories of Transmission-Based Precautions" (last revised January 2012) stated: For Contact Precautions, when possible, dedicate the use of non-critical resident-care equipment items such as a stethoscope, sphygmomanometer (blood pressure cuff), bedside commode, or electronic thermometer to a single resident (or cohort of residents) to avoid sharing between residents. If use of common items is unavoidable, then adequately clean and disinfect them before use for another resident. Under the section for contact precaution, Signs - The facility will implement a system to alert staff to the type of precaution resident requires. This facility utilizes the following system for identification of Contact Precautions for staff and visitors:_____. [the line was blank without facility-specific information.] 1. Review of R7's clinical record revealed: 6/14/18 - Order for contact precautions for urinary tract infection. 8/7/18 at 8:18 AM - Observation of medication pass: E30 (LPN) took the unit's vital sign machine into R7's room who is on contact precautions.	F 880	A. R7 and R14 were not affected by this deficient practice. The germicidal wipes were disposed of immediately and replaced with fresh wipes. The PPE was moved to the entrance door and signage was immediately posted. B. An isolation audit was completed to identify the appropriate PPE and signage was in place. C. Direct care staff, (Licensed and Certified) will be in-serviced by the staff development RN or designee on the Isolation Policy and Procedure with a focus on the guidelines/PPE placement and signage. D. Isolation audits to be conducted on appropriate PPE placement and signage weekly x 4, then monthly x 2 and until 100% compliance is achieved. The results will be reported to the QAPI Committee monthly x 3.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085020	A. BUILDING _____ B. WING _____	C 08/08/2018

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F 880	Continued From page 72 E30 stated there was not dedicated equipment in R7's room, so they have to use the unit's machine. After taking R7's vital signs, E30 wiped the vital sign machine down with Super-Sani-Cloth Germicidal Disposable Wipes. Surveyor noted that these wipes expired in August of 2014. E30 confirmed the expiration date and stated they would be replaced. 8/7/18 at 9:55 AM - During an interview: with E2 (DON) there was notification of the above information and E2 stated staff will check the expiration date of Germicidal Wipes on the medications carts and replace if needed. 2. Review of R14's clinical record revealed: 6/13/18 - Admission to the facility with admission orders for contact precautions for a urinary tract infection. 6/18/18 (4:06 PM) - Progress note documented the potential risk of a long term urinary catheter. Discussed risk of infection, sepsis and potential hospitalizations that are related to an indwelling foley catheter. Resident acknowledged understanding and agreed to have catheter removed. 6/19/18 (6:29 AM) - Progress note included catheter removed at 6:00 AM. Patient has bedpan in room. June - August 2018 - TAR shows contact isolation being signed off every shift by the nurse. 8/3/18 (approximately 2:50 PM) - Observation when verifying emergency tracheostomy supplies found no evidence that R14 was on contact precautions (no signage on the resident's door to	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 73 alert staff and visitors, no PPE hanging on outside of resident's door). 8/7/18 (8:50 AM) - Room observation discovered PPE hanging on bathroom door located on the far side of the resident's room. No signage on outside of room. 8/7/18 (9:31 AM) - Interview with E2 (DON) to inquire about the blank description in the policy. E2 confirmed that resident remained on contact precautions and stated "Let me go talk to the unit manager." 8/7/18 (11:10 AM) - Signage posted and PPE now located on the outside door of R14's room. 8/8/18 at approximately 3:15 PM - Above findings were reviewed with E1 (NHA) and E2 during Exit Conference.	F 880		
F 943 SS=D	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and	F 943		9/18/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 943	Continued From page 74 resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation it was determined that the facility failed to ensure the required training of abuse, neglect, exploitation and misappropriation was completed for 2 (E18 and E19) out of 11 sampled staff members. Findings include: Review of the documented completion of required abuse, neglect, exploitation and misappropriation training revealed no proof of the required training for: - E18: hired 2/15/05 - E19: hired 12/7/15 E1 (NHA) confirmed the inability to locate any documented evidence of training completion for two staff members. This finding was reviewed with E1 and E2 (DON) during the exit conference on 8/8/18 beginning at 3:15 PM.	F 943	A. E18 and E19 have been trained on the Abuse Policy and Procedure. No residents were impacted by this lack of training. No employees with perform direct care without abuse training. B. An educational audit was conducted on all employees to review compliance with the Abuse, Neglect and exploitation training. Any employee(s) identified as having not received the Abuse, Neglect and exploitation in-service was in-serviced. C. HR and Staff Development were in-serviced on abuse training requirement. All newly hired employees are required to complete the Abuse, Neglect and Exploitation training in Healthcare Academy prior to orientation. Monthly reports will be generated by the HR Director to ensure all employees are trained timely. D. Abuse, Neglect and Exploitation compliance training audits will be completed by the HR Director or designee weekly x4 until 100% compliance is achieved and monthly X3 and until 100% compliance is achieved. Results will be reported to the QAPI Committee monthly X3.	

DELAWARE HEALTH
AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care
Residents Protection

3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Pinnacle Rehabilitation and Health Center DATE SURVEY COMPLETED: August 8, 2018

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced complaint investigation survey and the extended survey was conducted at this facility from August 1, 2018 through August 8, 2018. The facility census on the first day of the survey was 141. The survey sample totaled 16.	The filing of this plan of correction does not constitute any admission as to any of the violations set forth in the statement of deficiencies. This plan of correction is being filed as evidence of the facilities continued compliance with all applicable law. The facility has achieved substantial compliance with all requirements as of the completion date specified in the plan of correction for the noted deficiencies. Therefore, the facility requests that this plan of correction serve as its allegation of substantial compliance with all requirements. Cross Refer CMS 2567-L survey completed 8/8/18: F585, F656, F657, F658, F684, F689, F695, F730, F755, F756, F760, F835, F842, F880, F943.	9/18/18
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed August 8, 2018: F585, F656, F657, F658, F684, F689, F695, F730, F755, F758, F760, F835, F842, F880, and F943.		

Provider's Signature TDonnell Title NHA Date 8/24/18